TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF PLANO

Respondent Name
BROTHERHOOD MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-16-1868-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "they have not paid what we determine is the correct allowable per the APC allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account. Per the new fee schedule this account qualifies for an Outlier payment"

Amount in Dispute: $2,142.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has reviewed its audit of the services provided and charges made and contends that it has paid the proper amount."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2015 to March 7, 2015	Outpatient Hospital	$2,142.92	$579.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

- 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 356 - THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 435 - PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 446 – THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 630 – THIS SERVICE IS PACKAGED WITH OTHER SERVICES PERFORMED ON THE SAME DATE AND REIMBURSEMENT IS BASED ON A SINGLE COMPOSITE APC RATE.
- B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for procedure code 96361 (subsequent hydration units add-on code) with claim adjustment reason code 446 – THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED. The provider billed initial IV push injection code 96374 for the same date of service. Procedure code 96374 is an allowable base code for add on hydration code 96361; therefore, the insurance carrier made an inappropriate denial of add-on hydration code 96361. The insurance carrier's denial reason is not supported. This service will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80053 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 83735 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 84100 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 84443 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 81001 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 72125 and 70450 have status indicator Q3 denoting conditionally packaged codes paid under composite APC 8005 if OPPS criteria are met. These services meet the criteria for composite payment. A service assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. Payment for composite services is calculated below.
- Procedure code G8980, date of service March 7, 2015, has status indicator E denoting non-covered items, codes or services not paid by Medicare when submitted on outpatient claims. Payment is not recommended.
- Procedure code 97001, date of service March 7, 2015, has status indicator A denoting a professional service paid by fee schedule. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2015 is $72.70. This amount divided by the Medicare conversion factor of 35.7547 and multiplied by the Division conversion factor of 56.2 yields a MAR of $114.27
- Procedure code 97116, date of service March 7, 2015, has status indicator A denoting a professional service paid by fee schedule. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate for this code for 2015 is $21.01. This amount divided by the Medicare conversion factor of 35.7547 and multiplied by the Division conversion factor of 56.2 yields a MAR of $33.02

- Procedure code 96361 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $18.60. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $31.63. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $31.63. This amount multiplied by 200% yields a MAR of $63.26.
- Per Medicare policy, procedure code 96372 may not be reported with procedure code 96374, 70553, and 70549 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96372 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $53.54. This amount multiplied by 60% yields an unadjusted labor-related amount of $32.12. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $30.55. The non-labor related portion is 40% of the APC rate or $21.42. The sum of the labor and non-labor related amounts is $51.97. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $51.97. This amount multiplied by 200% yields a MAR of $103.94.
- Per Medicare policy, procedure code 96374 may not be reported with procedure code 70553 and 70549 billed on the same claim. Payment for this service is included in the payment for other services billed on the same date. Separate payment is not recommended.
- Per Medicare policy, procedure code 96375 may not be reported with procedure codes 70553 and 70549 billed on the same claim. Payment for this service is included in the payment for the primary procedures. Separate payment is not recommended.
- Procedure code 99285 has status indicator Q3 denoting critical care packaged codes paid under composite APC 8009 if OPPS criteria are met. This service meets the criteria for composite payment. A service assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. Payment for composite services is calculated below.
- Procedure codes 70553, 70544 and 70549 have status indicator Q3 denoting conditionally packaged codes paid under composite APC 8008 if OPPS criteria are met. These services meet the criteria for composite payment. Services assigned to composite APCs are major components of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment for more than one otherwise separately payable service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. Payment for composite services is calculated below.
- Procedure code A9583 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2060 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 72125, and 70450 have status indicator Q3 denoting conditionally packaged codes paid under composite APC 8005. A service assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8005, for computed tomography (CT) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8005, which, per OPPS Addendum A, has a payment rate of $313.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $188.02. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $178.84. The non-labor related portion is 40% of the APC rate or $125.35. The sum of the labor and non-labor related amounts is $304.19. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $304.19. This amount multiplied by 200% yields a MAR of $608.38.
- Procedure codes 70553, 70544, and 70549 have status indicator Q3 denoting conditionally packaged codes paid through a composite APC. Services assigned to composite APCs are major components of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8008, for magnetic resonance imaging (MRI) services including contrast. If a “without contrast” MRI procedure is performed on the same date of service as a “with contrast” MRI, APC 8008 is assigned rather than APC 8007. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8008, which, per OPPS Addendum A, has a payment rate of $911.22. This amount multiplied by 60% yields an unadjusted labor-related amount of $546.73. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $520.05. The non-labor related portion is 40% of the APC rate or $364.49. The sum of the labor and non-labor related amounts is $884.54. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $884.54. This amount multiplied by 200% yields a MAR of $1,769.08.

- Procedure code 99285 has status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under critical care APC 8009, which, per OPPS Addendum A, has a payment rate of $1,234.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $740.82. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $704.67. The non-labor related portion is 40% of the APC rate or $493.88. The sum of the labor and non-labor related amounts is $1,198.55. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,198.55. This amount multiplied by 200% yields a MAR of $2,397.10.

4. The total allowable reimbursement for the services in dispute is $5,089.05. This amount less the amount previously paid by the insurance carrier of $4,509.90 leaves an amount due to the requestor of $579.15. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $579.15.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $579.15, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	March 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.